

109TH CONGRESS  
1ST SESSION

# H. R. 4063

To direct the Secretary of Health and Human Services to develop a policy for managing the risk of food allergy and anaphylaxis in schools.

---

## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 2005

Mrs. LOWEY (for herself, Mrs. MALONEY, Mr. EMANUEL, Mr. OWENS, Mr. MEEK of Florida, Ms. JACKSON-LEE of Texas, Ms. MILLENDER-MCDONALD, Mr. SHERMAN, Mr. SANDERS, Mr. LEVIN, and Mr. WEXLER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

## A BILL

To direct the Secretary of Health and Human Services to develop a policy for managing the risk of food allergy and anaphylaxis in schools.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the “Food Allergy and Ana-  
5       phylaxis Management Act of 2005”.

6       **SEC. 2. FINDINGS.**

7       The Congress finds as follows:

1           (1) Food allergy is an increasing food safety  
2           and public health concern in the United States, es-  
3           pecially among children.

4           (2) Peanut allergy doubled among children from  
5           1997 to 2002.

6           (3) In a 2003 survey of 400 elementary school  
7           nurses, 37 percent reported having at least 10 stu-  
8           dents with severe food allergies; 62 percent reported  
9           having at least 5.

10          (4) Forty-four percent of the elementary school  
11          nurses surveyed reported that the number of chil-  
12          dren in their school with food allergy had increased  
13          over the past 5 years; only 2 percent reported a de-  
14          crease.

15          (5) In a 2001 study of 32 fatal food-allergy in-  
16          duced anaphylactic reactions (the largest study of its  
17          kind to date), more than half (53 percent) of the in-  
18          dividuals were aged 18 or younger.

19          (6) Eight foods account for 90 percent of all  
20          food-allergic reactions: milk, eggs, fish, shellfish, tree  
21          nuts, peanuts, wheat, and soy.

22          (7) Currently, there is no cure for food aller-  
23          gies; strict avoidance of the offending food is the  
24          only way to prevent a reaction.

1           (8) Anaphylaxis, or anaphylactic shock, is a  
2           systemic allergic reaction that can kill within min-  
3           utes.

4           (9) Food-allergic reactions are the leading cause  
5           of anaphylaxis outside the hospital setting, account-  
6           ing for an estimated 30,000 emergency room visits,  
7           2,000 hospitalizations, and 150 to 200 deaths each  
8           year in the United States.

9           (10) Fatalities from anaphylaxis are associated  
10          with a delay in the administration of epinephrine  
11          (adrenaline), or when epinephrine was not adminis-  
12          tered at all. In a study of 13 food allergy-induced  
13          anaphylactic reactions in school-age children (6 fatal  
14          and 7 near fatal), only 2 of the children who died  
15          received epinephrine within 1 hour of ingesting the  
16          allergen, and all but one of the children who sur-  
17          vived received epinephrine within 30 minutes.

18          (11) The importance of managing life-threat-  
19          ening food allergies in the school setting has been  
20          recognized by the American Medical Association, the  
21          American Academy of Pediatrics, the American  
22          Academy of Allergy, Asthma and Immunology, and  
23          the American College of Allergy, Asthma and Immu-  
24          nology.

1           (12) There are no Federal guidelines con-  
2           cerning the management of life-threatening food al-  
3           lergies in the school setting.

4           (13) Three-quarters of the elementary school  
5           nurses surveyed reported developing their own train-  
6           ing guidelines.

7           (14) Relatively few schools actually employ a  
8           full-time school nurse. Many are forced to cover  
9           more than one school, and are often in charge of  
10          hundreds if not thousands of children.

11          (15) Parents of children with severe food aller-  
12          gies often face entirely different food allergy man-  
13          agement approaches when their children change  
14          schools or school districts.

15          (16) In a study of food allergy reactions in  
16          schools and day-care settings, delays in treatment  
17          were attributed to a failure to follow emergency  
18          plans, calling parents instead of administering emer-  
19          gency medications, and an inability to administer ep-  
20          inephrine.

21 **SEC. 3. ESTABLISHMENT OF FOOD ALLERGY AND ANAPHY-**  
22 **LAXIS MANAGEMENT POLICY.**

23          (a) ESTABLISHMENT.—Not later than 1 year after  
24 the date of the enactment of this Act, the Secretary of  
25 Health and Human Services shall—

1           (1) develop a policy to be used on a voluntary  
2           basis to manage the risk of food allergy and anaphy-  
3           laxis in schools; and

4           (2) make such policy available to local edu-  
5           cational agencies and other interested individuals  
6           and entities.

7           (b) CONTENTS.—The policy developed by the Sec-  
8           retary under subsection (a) shall address each of the fol-  
9           lowing:

10           (1) Parental obligation to provide the school,  
11           prior to the start of every school year, with docu-  
12           mentation from the student’s physician or nurse—

13                   (A) supporting a diagnosis of food allergy  
14                   and anaphylaxis;

15                   (B) identifying any food to which the stu-  
16                   dent is allergic;

17                   (C) describing, if appropriate, any prior  
18                   history of anaphylaxis;

19                   (D) listing any medication prescribed for  
20                   the child for the treatment of anaphylaxis;

21                   (E) detailing emergency treatment proce-  
22                   dures in the event of a reaction;

23                   (F) listing the signs and symptoms of a re-  
24                   action;

1 (G) assessing the student's readiness for  
2 self-administration of prescription medication;  
3 and

4 (H) providing a list of substitute meals  
5 that may be offered by school food service per-  
6 sonnel.

7 (2) The maintenance of a file by the school  
8 nurse or principal for each student at risk for ana-  
9 phylaxis.

10 (3) Communication strategies between indi-  
11 vidual schools and local providers of emergency med-  
12 ical services, including appropriate instructions for  
13 emergency medical response.

14 (4) Strategies to reduce the risk of exposure to  
15 anaphylactic causative agents in classrooms and  
16 common school areas such as the cafeteria.

17 (5) The dissemination of information on life-  
18 threatening food allergies to school staff, parents,  
19 and students, if appropriate by law.

20 (6) Food allergy management training of school  
21 personnel who regularly come into contact with stu-  
22 dents with life-threatening food allergies.

23 (7) The authorization of school personnel to ad-  
24 minister epinephrine when the school nurse is not  
25 immediately available.

1           (8) The timely accessibility of epinephrine by  
2       school personnel when the nurse is not immediately  
3       available.

4           (9) Extracurricular programs such as non-aca-  
5       demic outings and field trips, before- and after-  
6       school programs, and school-sponsored programs  
7       held on weekends.

8           (10) The creation of an individual health care  
9       plan tailored to the needs of each individual child at  
10      risk for anaphylaxis, including any procedures for  
11      the self-administration of medication by such chil-  
12      dren in instances where—

13                 (A) the children are capable of self-admin-  
14                 istering medication; and

15                 (B) such administration is not prohibited  
16                 by State law.

17           (11) The collection and publication of data for  
18       each administration of epinephrine to a student at  
19       risk for anaphylaxis.

20       (c) RELATION TO STATE LAW.—Nothing in this Act  
21   or the policy developed by the Secretary under subsection  
22   (a) shall be construed to preempt State law, including any  
23   State law regarding whether students at risk for anaphy-  
24   laxis may self-administer medication.

25       (d) DEFINITIONS.—In this Act:

1           (1) The term “school” includes kindergartens,  
2           elementary schools, and secondary schools.

3           (2) The term “Secretary” means the Secretary  
4           of Health and Human Services.

○